

CERTIFICATE OF DEATH

00708

00703

1. PLACE OF DEATH a. COUNTY <i>Howard</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Sykesville</i> c. LENGTH OF STAY IN b. <i>14 years</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Howard</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Sykesville</i> d. STREET ADDRESS <i>Old Andriatic Road</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Franklin J. Anderson</i> First Middle Last		4. DATE OF DEATH <i>Jan. 31 1962</i> Month Day Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 27, 1903</i> 9. AGE (In years last birthday) <i>58 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lawyer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Law</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>James M. Anderson</i>		14. MOTHER'S MAIDEN NAME <i>Alice Ball</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown)		16. SOCIAL SECURITY NO. <i>Mr. Catherine Anderson - Sykesville, Md.</i>	
17. INFORMANT <i>Mr. Catherine Anderson - Sykesville, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Dehydration</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Excessive Vomiting Acidosis</i> DUE TO (c) <i>Spastic Colitis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Malnutrition</i> INTERVAL BETWEEN ONSET AND DEATH <i>One week</i> <i>One week</i> <i>20 years</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 30, 1962</i> to <i>Jan 31, 1962</i> , that (I) (we) last saw the deceased alive on <i>Jan 30, 1962</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Sani Okutman</i> M.D.		22b. DATE <i>Feb. 1, 1962</i> SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Sani Okutman</i>		22d. ADDRESS <i>Sykesville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>2-2-62</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Harmony</i>	23d. LOCATION (City, town or county) (State) <i>Crookville, Howard Co. Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Julius A. Wright</i> ADDRESS <i>Sykesville, Md.</i>		25a. RECEIVED BY REGISTRAR <i>FEB 5 '62</i> DATE <i>FEB 5 '62</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 8 & 9 Film G305 1/26/62 iwk

00709

CERTIFICATE OF DEATH

Reg. Dist. No.

00704

1. PLACE OF DEATH a. COUNTY HOWARD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO. H.H. ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 02X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LARK BROWN RD., HOWARD				d. STREET ADDRESS 308 SHENANDOAH AVE. #25			
3. NAME OF DECEASED (Type or print) First ANTONINIA Middle BENCH Last (nee BARTOSKEWICZ)				4. DATE OF DEATH Month 1 Day 18 Year 1962			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. (?) 1871	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 1 Days 18 Hours 18 Min.		IF UNDER 24 HRS. Months 1 Days 18 Hours 18 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY LITHUANIA			
11. BIRTHPLACE (State or foreign country) LITHUANIA				12. CITIZEN OF WHAT COUNTRY? LITHUANIA ✓			
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. JOSEPH BENCH, 1809 LANCASTER AVE. #31			
17. INFORMANT JOSEPH BENCH, 1809 LANCASTER AVE. #31				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arterio-Sclerosis 450.0 DUE TO Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility DUE TO (c) Senility INTERVAL BETWEEN ONSET AND DEATH 3 yrs. 2 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) BALTIMORE				20g. (County) MARYLAND		20h. (State) MARYLAND	
21. I certify that I attended the deceased from Jan. 1st, 1961 , to Jan. 18th, 1962 , that I last saw the deceased alive on Jan. 18th, 1962 , and that death occurred at 6 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank E. Shipley, M.D.				DATE SIGNED 1/20/62			
PHYSICIAN'S NAME (Type) Frank E. Shipley, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-22-62		22c. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Cowan & Sons Inc., Hollins & Poppleton				24a. REC'D BY REGISTRAR JAN 23 '62		24b. REGISTRAR'S SIGNATURE James S. Pless	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

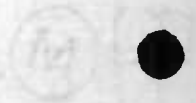
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00710

CERTIFICATE OF DEATH

Reg. Dist. No. 00705

1. PLACE OF DEATH a. COUNTY Howard County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffers Convalescent Retreat		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - #4 d. STREET ADDRESS 1723 Kennoway Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Dr. Lorenzo B. EVANS		4. DATE OF DEATH Month Day Year Jan. 24 1962	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/12/1876
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor		10b. KIND OF BUSINESS OR INDUSTRY Medical	11. BIRTHPLACE (State or foreign country) Deep Valley, Pa.
13. FATHER'S NAME Evans		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
INFORMANT Address Lorenzo B. Evans, Jr. 1723 Kennoway Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripheral Vascular Collapse DUE TO (b) Cardiac Failure DUE TO (c) Arteriosclerotic Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 hrs 2 da 10 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5-31, 1962 to 1-24, 1962 that I last saw the deceased alive on 1-23, 1962, and that death occurred at 1:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Thomas F. Herbert, M.D.			
PHYSICIAN'S NAME (Type) Thomas F. Herbert, Ellicott City, Md. 1-25-62			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/27/62	22c. NAME OF CEMETERY OR CREMATORY Park Moreland Memorial Com.	22d. LOCATION (City, town, or county) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.		24a. REC'D BY REGISTRAR DATE JAN 29 '62	24b. REGISTRAR'S SIGNATURE Arthur J. Hanes



Chief Clerk

00710

CHURCH OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00711

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11706

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodbine</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural - Woodbine</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>-</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANKLIN WAUGH GLASCOCK</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>18</u> Year <u>1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 21, 1894</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Horse Trainer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Riding School</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George Glascock</u>		14. MOTHER'S MAIDEN NAME <u>ANDREA Waugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Wife</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420-1 DUE TO <u>Anterior Septal Cardiac Vessel Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>10 yrs.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 mon.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Thomas F. Herbert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Thomas F. Herbert M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-20-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Glenwood, Howard, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. & Hark</u>				ADDRESS <u>11111 1st St. N.W. Washington, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 22 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MAY 1963 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. RACE [Faint text]	
5. DATE OF BIRTH [Faint text]		6. PLACE OF BIRTH [Faint text]	
7. DATE OF DEATH [Faint text]		8. PLACE OF DEATH [Faint text]	
9. TIME OF DEATH [Faint text]		10. CAUSE OF DEATH [Faint text]	
11. MANNER OF DEATH [Faint text]		12. SIGNATURE OF EXAMINER [Faint text]	
13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF CORONER [Faint text]	
15. SIGNATURE OF JURY [Faint text]		16. SIGNATURE OF JURY [Faint text]	
17. SIGNATURE OF JURY [Faint text]		18. SIGNATURE OF JURY [Faint text]	
19. SIGNATURE OF JURY [Faint text]		20. SIGNATURE OF JURY [Faint text]	
21. SIGNATURE OF JURY [Faint text]		22. SIGNATURE OF JURY [Faint text]	
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79. SIGNATURE OF JURY [Faint text]		80. SIGNATURE OF JURY [Faint text]	
81. SIGNATURE OF JURY [Faint text]		82. SIGNATURE OF JURY [Faint text]	
83. SIGNATURE OF JURY [Faint text]		84. SIGNATURE OF JURY [Faint text]	
85. SIGNATURE OF JURY [Faint text]		86. SIGNATURE OF JURY [Faint text]	
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89. SIGNATURE OF JURY [Faint text]		90. SIGNATURE OF JURY [Faint text]	
91. SIGNATURE OF JURY [Faint text]		92. SIGNATURE OF JURY [Faint text]	
93. SIGNATURE OF JURY [Faint text]		94. SIGNATURE OF JURY [Faint text]	
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97. SIGNATURE OF JURY [Faint text]		98. SIGNATURE OF JURY [Faint text]	
99. SIGNATURE OF JURY [Faint text]		100. SIGNATURE OF JURY [Faint text]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4, Film G-305 1/8/62. cac.

CERTIFICATE OF DEATH

Reg. Dist. No.

00707

00712

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. COUNTY Howard Elkridge					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5523 Race Rd.				d. STREET ADDRESS 5523 Race Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CORA Middle GREEN Last				4. DATE OF DEATH Month Jan. Day 22 Year 1962					
5. SEX Female		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 17, 1889			
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY?			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elkridge Md.			
13. FATHER'S NAME Moses Green				14. MOTHER'S MAIDEN NAME Ida Gross					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT James Brown Address 5523 Race Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 1 hr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2 JAN , 19 62 , to 2 JAN , 19 62 ; that I last saw the deceased alive on 2 JAN , 19 62 , and that death occurred at 4 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George E. Groleau M.D. 5608 Main St Elkridge 27 Md 4 Jan 62 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) George E. Groleau 5608 Main St Elkridge 27 Md									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
Burial		1/6/1962		St. James Cem.		Elkridge Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Kate Rhodians Schroeder				ADDRESS 322 N.		24a. REC'D BY REGISTRAR DATE JAN 8 '62			
						24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00713 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Howard Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkridge				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkridge			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1113 Montgomery Road				d. STREET ADDRESS 1113 Montgomery Road			
3. NAME OF DECEASED (Type or print) First Middle Last Thelma Louise Graham Harless				4. DATE OF DEATH Month Day Year January 23 1962			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb. 11, 1915	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY New Key Market		11. BIRTHPLACE (State or foreign country) W. V. West Virginia		12. CITIZEN OF WHAT COUNTRY? Yes U.S.A.	
13. FATHER'S NAME Thomas Graham				14. MOTHER'S MAIDEN NAME Ethel Masters			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Nellie Chapman West Virginia			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Russell S. Fisher				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED January 24, 1962	
EXAMINER'S NAME (Type) Russell S. Fisher, M. D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-28-62		22c. NAME OF CEMETERY OR CREMATORY Maple Grove Cem.		22d. LOCATION (City, town, or county) (State) Fairmont West Virginia	
23. FUNERAL DIRECTOR Howard H. Hubbard 4167 Wilkins Ave				24a. REC'D BY REGISTRAR DATE JAN 29 '62		24b. REGISTRAR'S SIGNATURE Arthur E. Harris	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00714

Items 7, 13 & 14 Film G306 2/5/62 iwr

00709

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Schaeffer's Convalescent Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE md b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3v01-4 d. STREET ADDRESS 1643 ABBOTTSON ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mathilda Middle Julia Last Hessler		4. DATE OF DEATH Month Jan. Day 24 Year 1962	
5. SEX Female		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/26/1878	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 5 Days 1 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown Boudon		14. MOTHER'S MAIDEN NAME Pauline unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MR. August Hessler-Ellicott City		Address 322 Rogers.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, lobar, rt. lower lobe 490X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 da.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. Month, Day, Year 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (U) (this hospital) attended the deceased from 6-19 , 1961, to 1-24 , 1962, that (I) (we) last saw the deceased alive on 1-23 , 1962, and that death occurred at 1:50 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Herbert M.D.		22b. DATE SIGNED 1-24-62	
22c. PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.		22d. ADDRESS Ellicott City, Maryland	
23. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1-27-62	
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City, town or county) (State) BALTIMORE Md	
24. FUNERAL DIRECTOR'S SIGNATURE Leland Luck ADDRESS 5305 Hayford Rd		25a. REC'D BY REGISTRAR JAN 29 '62 DATE	
25b. REGISTRAR'S SIGNATURE Arthur S. Knaus			

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Harvard

Elmer C. Smith

Residence

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Cambridge

Massachusetts

Boston

Mr. August Hasker

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Massachusetts

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Howard Co. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Box 213A Elkridge 27, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Howard c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkridge 27, Md. d. STREET ADDRESS Box 213A e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alexander Hughes-Wynn-Fields		4. DATE OF DEATH Month 1 Day 28 Year 1962	
5. SEX male		6. COLOR OR RACE colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-11-1910	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		11. BIRTHPLACE (County & State, or foreign country) Baltimore Co. USA	
13. FATHER'S NAME Gary Fields		14. MOTHER'S MAIDEN NAME Aguilla Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) No		17. INFORMANT Address Dorothy Alaba SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Valvular & Hypertension 4432X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Chronic Alcoholism DUE TO (c) Enlarged liver		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 9 , 19 61 , to Jan 28 , 19 62 , that (I) (we) last saw the deceased alive on Jan 23 , 19 62 , and that death occurred at 7 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Thos Woolbridge		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Thos Woolbridge		22d. ADDRESS 184 Box 212 Elkridge 27 Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-1-62	
23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat Cem		23d. LOCATION (City, town or county) (State) Baltimore Md	
24. FUNERAL DIRECTOR'S SIGNATURE Choy O Wilson		25a. REC'D BY REGISTRAR 1000 Southern Ave	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas		25c. DATE JAN 31 '62	

(M)

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Howard

Elkridge 27th

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Boys 27th

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Alexander Hughes

11-11-1910

Male Cabot

USA

Baltimore Co.

Agnes Brown

Long Hills

1918-1919 Troth Aloa SAME

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00716

00711

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 19 New Cut Road		d. STREET ADDRESS 19 New Cut Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First OLA Middle JOHNSON Last		4. DATE OF DEATH Month Jan. Day 14 Year 1962	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> (See) DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1887
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME John Cole	
14. MOTHER'S MAIDEN NAME Lolly Cole		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Violette Beverly 2805 W. Fayette Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO VASCULAR ACCIDENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 12 HRS 10 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1960 to 1-14 , 19 62 that (I) (we) last saw the deceased alive on 1-13 , 19 62 , and that death occurred on 8:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE P. V. Thorpe		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) PETER V. THORPE, MD		22d. ADDRESS 409 COLUMBIA RD, ELLICOTT CITY, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/18/62	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Granit, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE A. Halstead 918 Druid Hill Ave. Balto.1, Md.		25a. REC'D BY REGISTRAR DATE JAN 16 '62	25b. REGISTRAR'S SIGNATURE Arthur S. Thomas

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Charles S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00718 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00713

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Duvall Road				d. STREET ADDRESS Duvall Road			
3. NAME OF DECEASED (Type or print) First ELLA Middle MAY Last JUNKINS				4. DATE OF DEATH Month January Day 17 Year 19 62			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 22, 1915	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months 46 Days	IF UNDER 24 HRS. Hours 46 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY Woodbine, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Bruce Junkins				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Catherine Junkins, Duvall Rd. Woodbine, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic and Hypertensive Cardiovascular Disease. Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause first. 443 X (b) None (c) None DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Partial		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type) Charles S. Petty, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/18/62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-20-62		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		22d. LOCATION (City, town, or country) (State) Sunshine, Md	
23. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR JAN 22 1962			



Page 1

Page 2

Page 3

Page 4

Page 5

Page 6

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
00719 MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY HOWARD					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY HOWARD									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARRIOTTSTVILLE					c. LENGTH OF STAY IN 1b Marriottsville									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HENRYTOWN ROAD					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) GEORGE ALEXANDER KING					4. DATE OF DEATH Month 1 Day 21 Year 1962									
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 18, 1910		9. AGE (In years last birthday) 51 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.								
13. FATHER'S NAME John A. King					14. MOTHER'S MAIDEN NAME Alice Sands									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) yes W.W. II					16. SOCIAL SECURITY NO. W.W. II					17. INFORMANT Mr. Alma Johnson - 5 Jones ave., Catonsville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE Russell S. Fisher					CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>									
EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
					DATE SIGNED 1-22-62									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-24-62		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or country) (State) Baltimore, Md.								
23. FUNERAL DIRECTOR Arthur H. Haight					24a. REC'D BY REGISTRAR Arthur S. Haight		24b. REGISTRAR'S SIGNATURE Arthur S. Haight							

00719

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00720

Item 14 Film G305 1/10/62 iwk

06715

1. PLACE OF DEATH e. COUNTY <i>Howard County</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <i>Maryland</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Ellicott City</i>		c. LENGTH OF STAY IN 1b <i>6 mos to year</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Old Frederick Rd.</i>		d. STREET ADDRESS <i>11 E. Kenneth St.</i>	
3. NAME OF DECEASED (Type or print) First <i>GRACE</i> Middle <i>E.</i> Last <i>KIRBY</i>		4. DATE OF DEATH Month <i>1</i> Day <i>3</i> Year <i>19 62</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/28/87</i>
9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR Months <i>1</i> Days <i>3</i>	IF UNDER 24 HRS. Hours <i>19</i> Min. <i>62</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>unknown</i>	
13. FATHER'S NAME <i>- Moody</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Family</i>	
17. INFORMANT <i>Family</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure, Aneurysm, dissection</i> DUE TO (b) <i>Carcinoma of rectum & metastasis</i> DUE TO (c) <i>Generalized</i> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>1959 to 1962</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1959</i> , 19... to <i>1962</i> , 19..., that (I) (we) last saw the deceased alive on <i>3 Jan 1962</i> , and that death occurred at <i>10:30 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Howard E. Hall</i>		22b. DATE SIGNED <i>3 Jan 62</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>Spheville, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/8/62</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Balto. 25, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>McCully Funeral Homes 130 E. Fort Ave.</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 5 '62</i>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>C. L. S. Hume</i>	

00720

11281

Grave

Grave of John & Mary
Grave of John & Mary

Grave of John & Mary

Grave of John & Mary

Grave of John & Mary

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00721

00716

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkridge				c. LENGTH OF STAY IN 1b X Elkridge			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Behind 6714 Washington Blvd. in woods				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Roger F. Knight				4. DATE OF DEATH Jan. 22, 1962 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 24, 1907	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sr. Supervisor Baltimore City		10b. KIND OF BUSINESS OR INDUSTRY Sewer Dept.		9. AGE (In years last birthday) 54 yrs.		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Jeremiah R. Knight			
14. MOTHER'S MAIDEN NAME Katie L. Snyder				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. 218-26-5382				17. INFORMANT Lillian E. Knight, Elkridge, Md. Address 6714 Washington Blvd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation from hanging DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 974X (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 10 min.	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Hung himself from a tree				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 1-22-1962 Hour a.m. 1:15 P.M.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods		20f. (City or town) Elkridge (County) Howard (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE George E. Burgtorf				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) George E. Burgtorf M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 1-22-1962			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/25/62		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or country) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR Howard H. Hubbard ADDRESS 4107 Wilkens Avenue #29				24a. REC'D BY REGISTRAR JAN 24 '62		24b. REGISTRAR'S SIGNATURE Charles S. Hanna	

0075

M

1-1-1952

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1 & 2, Telephone Call From Wm. Tickner 1/19/62 jml

00722

CERTIFICATE OF DEATH

Reg. Dist. No.

00717

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>HOWARD</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>River Road</u>				d. STREET ADDRESS <u>River Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Nina</u> Middle <u>Vickers</u> Last <u>METTEE</u>				4. DATE OF DEATH Month <u>January</u> Day <u>8</u> Year <u>1962</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10, 1914</u>	9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary - Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Solon E. Vickers</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Baekey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-40-5073</u>		INFORMANT Address <u>Mr. N. Boyd Mettee-River Road- Sykesville, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured dissecting Abdominal Aorta</u> DUE TO <u>arterio-sclerosis - shock,</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1962</u> <u>to</u> <u>1962</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>8 Jan</u> , 19 <u>62</u> to <u>8 Jan</u> , 19 <u>62</u> ; that I last saw the deceased alive on <u>8 Jan</u> , 19 <u>62</u> , and that death occurred at <u>10:00 P.M.</u> , from the causes and on the date stated above.							DATE SIGNED <u>9 Jan 62</u>
ACTUAL SIGNATURE <u>Howard E. Hall</u>				ADDRESS (Street, city or town, state) <u>Sykesville, Md</u>			
PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M. D.</u>				SYKESVILLE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-11-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Havre-de-Grace, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Tickner & Sons Baltimore 17, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 11 '62</u>		24b. REGISTRAR'S SIGNATURE	

M

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MEDICAL CERTIFICATION

VS A15 (4)
15M 9/58



DATE OF BIRTH
PLACE OF BIRTH

DATE OF DEATH
PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

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TO HOSPITAL OR FUNERAL HOME. The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. It may be obtained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00723
CERTIFICATE OF DEATH
00718

1. PLACE OF DEATH a. COUNTY <u>Laward</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jesup</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Laney Run Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u> d. STREET ADDRESS <u>22X-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Emma Agnes Pusey</u> First Middle Last			4. DATE OF DEATH <u>January 20 1962</u> Month Day Year				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16, 1893</u> Month Day Year	9. AGE (in years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>James E. Harman</u>			14. MOTHER'S MAIDEN NAME <u>Flaurence Gill</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Catherine Small</u> Address <u>Laney Run Rd Jesup</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u>Congestive Heart Failure</u> (c) <u>Chronic</u>				INTERVAL BETWEEN ONSET AND DEATH <u>None</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>January 16, 1962</u> to <u>January 20, 1962</u> , that (I) <u>no</u> last saw the deceased alive on <u>January 16, 1962</u> and that death occurred at <u>Jesup</u> from the cause and on the date stated above.							
22a. SIGNATURE <u>Robert C. Wingfield</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>January 20, 1962</u>			
22c. PHYSICIAN'S NAME (Type) <u>ROBERT C. WINGFIELD</u>		22d. ADDRESS <u>Lanard, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/22/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mendowidge Park</u>			
23d. LOCATION (City, town or county) <u>Laney Rd</u>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter S. Sanderlin</u>		ADDRESS <u>Lanard, Md.</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Harris</u>			
DATE <u>JAN 29 '62</u>		25b. REGISTRAR'S SIGNATURE					

M

00720

STATE OF CALIFORNIA

IN SENATE, January 10, 1907.

REPORT

of the
Commissioners of the
State Lands Office,
for the year ending
December 31, 1906.
Submitted to the
Senate by the
Commissioners,
January 10, 1907.
J. W. B. [Signature]
Commissioner of State Lands
J. W. B. [Signature]
Secretary of State

CERTIFICATE OF DEATH

01-22

(M)

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 8 & 9 Film G306 2/2/62 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

00720

00725

1. PLACE OF DEATH Howard a. COUNTY <u>ANNAPOLIS</u> <u>Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>—</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELLICOTT CITY</u>				c. LENGTH OF STAY IN 1b <u>—</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SHAFER NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>LESTER RUBY</u>				4. DATE OF DEATH Month Day Year <u>JAN 7, 1962</u> 19					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1886</u> <u>JULY 26, 1884</u> 75 yrs.			
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Months		Days		Hours		Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED ENG.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>P.A.R.A.</u>					
11. BIRTHPLACE (State or foreign country) <u>PA</u>				12. CITIZEN OF WHAT COUNTRY? <u>—</u>					
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>					
17. INFORMANT <u>Stup</u> <u>CLARA S. STAIR</u>				Address <u>833 UNION AVE.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral Vascular Collapse</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac Failure</u> DUE TO (c) <u>Arterio-sclerotic Cardiovascular Disease</u>								INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>48 hrs.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)		(State)			
21. I certify that I attended the deceased from <u>Jan 2, 1962</u> , to <u>Jan 7, 1962</u> , that I last saw the deceased alive on <u>Jan 6, 1962</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1/9/62</u> DATE SIGNED ACTUAL SIGNATURE <u>Thomas F. Herbert</u> M.D. <u>46 Church Road, Ellicott City, Md.</u>									
PHYSICIAN'S NAME (Type) <u>Thomas F. Herbert, M. D.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN 10, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul E. Chomsky, 3617 Chestnut Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 12 '62</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thoms</u>			

CERTIFICATE OF DEATH

00228

NAME OF DECEASED <i>John Doe</i>		SEX <i>Male</i>	DATE OF BIRTH <i>10-15-1920</i>
RESIDENCE <i>123 Main St, Baltimore, MD</i>		OCCUPATION <i>Teacher</i>	
DATE OF DEATH <i>11-10-1985</i>		PLACE OF DEATH <i>Home</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
IMMEDIATE CAUSE OF DEATH <i>Myocardial Infarction</i>		UNDERLYING CAUSE OF DEATH <i>Coronary Artery Disease</i>	
DATE OF AUTOPSY <i>11-15-1985</i>		PLACE OF AUTOPSY <i>Johns Hopkins Hospital</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	
DATE OF SIGNATURE <i>11-10-1985</i>		DATE OF SIGNATURE <i>11-10-1985</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00721

00726

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shafer's Convalescent Retreat		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDNA SHIPLEY		4. DATE OF DEATH Jan. 26, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1893
9. AGE (In years last birthday) 68 yrs.		10. BIRTHPLACE (State or foreign country) Baltimore, Md	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Nitzel		14. MOTHER'S MAIDEN NAME Anita Patchi	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Raymond Dorn, 33 N St. Johns Lane, Ellicott		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, colon, metastatic 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-27 , 19 61 , to 1-26 , 19 62 , that I last saw the deceased alive on 1-26 , 19 62 , and that death occurred at 9:30 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas F. Herbert, M.D.		ADDRESS (Street, city or town, state) 46 Church Road, Ellicott City, Md	
DATE SIGNED 1-26-62			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-29-62	
22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE JAN 29 '62	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraw			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

00727

CERTIFICATE OF DEATH

Reg. Dist. No.

00722

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffers Convalescent Retreat				d. STREET ADDRESS Bethany Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES F. SINGHASS				4. DATE OF DEATH Month Day Year Jan. 11, 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 26, 1888	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Christian J. Singhass				14. MOTHER'S MAIDEN NAME Iena Stump			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-32-2224		INFORMANT Address Mrs. Phillip German, Bethany Lane, Ellicott City			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Larcinoma of Prostate Gland. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). None						INTERVAL BETWEEN ONSET AND DEATH 2 hours 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 10, 1958 to Jan 11, 1962 that I last saw the deceased alive on Jan 8, 1962 , and that death occurred at 9 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ellicott City, Md. DATE SIGNED 1/11/62							
ACTUAL SIGNATURE William F. Lassaway		M.D. Ellicott City, Md.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-15-1962		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive		22d. LOCATION (City, town, or county) (State) Randallstown, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				ADDRESS		24a. REC'D BY REGISTRAR JAN 15 '62	
						24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

CERTIFICATE OF DEATH

1907

I, J. H. [illegible]

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00728 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00723

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, give the date and time of delay in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Clarksville c. LENGTH OF STAY IN lb 6 months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cedar Lane				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Clarksville d. STREET ADDRESS Cedar Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle Page Last Tribble				4. DATE OF DEATH Month January Day 16 Year 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 17, 1888	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 16		IF UNDER 24 HRS. Hours 16 Min. 16			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Elec. Appliance		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Tribble				14. MOTHER'S MAIDEN NAME Nannie Page			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. W.W. I m 047-07-8303			
17. INFORMANT Charles P. Taylor				Address Clarksville, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 331X							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Whitaker				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles S. Whitaker, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial				22b. DATE THEREOF 1/17/1962			
22c. NAME OF CEMETERY OR CREMATOR London Park				22d. LOCATION (City, town, or country) (State) Baltimore Md.			
23. FUNERAL DIRECTOR Loring Byers				24a. REC'D BY REGISTRAR JAN 18 '62			
ADDRESS 8728 Liberty Rd. Randallstown, Md.				24b. REGISTRAR'S SIGNATURE Conrad S. Thoms			

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DEATH CERTIFICATE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00730											
00725											
1. PLACE OF DEATH a. COUNTY <u>Howard</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harvey</u> c. LENGTH OF STAY IN 1b <u>9 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harvey</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harvey</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>John C.</u> Middle <u>Walsh</u> Last <u>Walsh</u>						4. DATE OF DEATH Month <u>Jan</u> Day <u>1</u> Year <u>1962</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 27, 1891</u>		9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>guard</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>US Coast Guard</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Washington Indiana</u>			
13. FATHER'S NAME <u>Nichols J. Walsh</u>						14. MOTHER'S MAIDEN NAME <u>Jane Kinsella</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>705-12-0323</u>		17. INFORMANT <u>Thos Virginia Harman Harvey Md</u>		Address <u>Harvey Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO <u>422.1</u> (c) <u>Arteriosclerotic Cardiovascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> e.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>January 1, 1962</u> to <u>January 1, 1962</u> that (I) (we) last saw the deceased alive on <u>January 1, 1962</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>E. Roderick Shipley</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-1-62</u>			
22c. PHYSICIAN'S NAME (Type) <u>E. Roderick Shipley</u>						22d. ADDRESS <u>529 Camp Meade Road, Linthicum</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1/3/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Headamridge</u>				23d. LOCATION (City, town or county) (State) <u>Harvey Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert R. Roderick</u>						ADDRESS <u>Harvey Md</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 5 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Harris</u>	

00730

RECEIVED ON DEATH

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[Faint, mostly illegible handwritten text, possibly a letter or document, covering the majority of the page.]

IN E. B.

[Faint handwritten text at the bottom right, possibly a signature or date.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased was in the hospital or nursing home, the certificate may be completed by the attending physician and completely filled in by the funeral director. If the deceased was not in the hospital or nursing home, the certificate may be completed by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00726

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1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Howard	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural- Long Corner		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural- Long Corner		d. STREET ADDRESS RFD 3, Mt. Airy	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RFD 3, Mt. Airy		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4. DATE OF DEATH Month Jan.		Year 1962	
3. NAME OF DECEASED (Type or print) Edgar		First Edgar		Middle -		Last Warfield	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1, 1901	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 60		IF UNDER 24 HRS. Days 60		Hours 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auctioneer and farmer		10b. KIND OF BUSINESS OR INDUSTRY Frederick Co., Md.		11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter H. Warfield		14. MOTHER'S MAIDEN NAME Frances Mary Day		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-12-6263	
17. INFORMANT Mrs Lucy V. Warfield, Item 2		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO 241X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Bronchial asthma (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 6 years 15 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 4/10		(County) 1958	
20g. (State) 1962		21. I certify that (I) (this hospital) attended the deceased from 4/10 to 1/11 , 1962 that (I) (we) last saw the deceased alive on 12/30 , 1961, and that death occurred at 1:10P , from the causes and on the date stated above.		22a. SIGNATURE James P. Kerr		22b. DATE SIGNED 1/13/62	
22c. PHYSICIAN'S NAME (Type) James P. Kerr		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS Damascus, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 4, 1962		23c. NAME OF CEMETERY OR CREMATORY Prospect		23d. LOCATION (City, town or county) Nr. Mt. Airy, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Molsmith		ADDRESS Damascus, Md.		25a. REC'D BY REGISTRAR JAN 4 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

MEDICAL CERTIFICATION



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